

Exhibit 1

Accountable Hospital Care Organization Value Based Incentive Payment

This Exhibit 1 sets forth additional terms for purposes of an Accountable Hospital Care Organization participating in the Value-Based Incentive Payment program; provided, however, in the event of a discrepancy or conflict between this Exhibit and the VCO Agreement, this Exhibit will take precedence.

Article I

The following terms are in addition to the terms defined in the VCO Agreement. As used in this Exhibit, the following terms shall have the meanings set forth below:

- 1.1 Accountable Hospital Care Organization (AHCO):** A VCO consisting of an integrated network of at least one acute care hospital and panel of Primary Care Providers whose Healthy Connections Service Locations are collectively Assigned at least 10,000 Medicaid Participants. Hospital systems participating in an AHCO must, unless an exception is granted by the Department, include all its Acute Care Hospital locations and Healthy Connections Service Locations in the AHCO service area.
- 1.2 Actual Cost:** The sum of all Included Costs as defined in Exhibit 1D for Participants Attributed to the VCO incurred based on date of service during the Base Year, and each Performance Year, adjusted for Stop Loss as defined herein. In determining total Actual Cost for the Base Year and each Performance Year, the Department will account for all claims incurred during the period and paid during the period and the three months following the period allowing for a three-month runout. In the event a three-month run out period is insufficient due to a significant change in claims lag at the end of a Performance Year, the Parties will mutually agree on a method for applying an Incurred But Not Reported (IBNR) adjustment to the Actual Cost calculation.
- 1.3 Actual Cost Per Member Per Month (PMPM):** The Actual Cost PMPM for the Base Year and each Performance Year shall be calculated by dividing the Actual Cost for the period by the number of Member Months for that period.
- 1.4 Base Year:** State Fiscal Year 2019, the twelve-month period beginning July 1, 2018 and ending June 30, 2019.
- 1.5 Baseline Score:** VCO's "starting point" to determine the amount of improvement required for a quality measure score to qualify for an incentive payment. For the first Performance Year, the Baseline Score would be the VCO's quality measure status as of, June 30, 2019.

- 1.6 Gross Target PMPM:** The per-member, per-month target established each Performance Year specific to the VCO. Gross Target PMPM is calculated based on the VCO's Actual Costs in the Base Year, risk-adjusted, and trended forward for inflation as described in Article 3.4.
- 1.7 Gross Target:** Gross Target shall be calculated by multiplying the Gross Target PMPM by the total Member Months Attributed to the VCO during the Performance Year.
- 1.8 Included Cost:** The expenses of Department for a Participant that will be counted in the calculation of Actual Cost, as set forth in Exhibit 1D.
- 1.9 Incremental Annual Improvement Target:** The percentage of improvement required annually, per quality measure, to qualify for an incentive payment.
- 1.10 Inflation Trend:** The Milliman Medical Index (MMI) published during each Performance Year will be applied to trend costs forward in setting the Gross Target PMPM for each Performance Year. The Inflation Trend index applied each year will be capped at an increase or decrease of 1.0% from the index used in calculating the previous year Gross Target PMPM. The actual calculation of the Inflation Trend index is described in Exhibits 1A, 1B and 1C.
- By way of example if the index used to develop the prior year Gross Target PMPM was 4.0% and the index for the current year is 5.3%, the index used to calculate the current year Gross Target PMPM would be 5.0%, the lesser of 5.3% and 5.0% (4.0% + 1.0%). Conversely, if the index used in the prior year was 4.0% and the current year index is 2.7%, the index used in the current year would be 3.0%, the greater of 2.7% and 3.0% (4.0% - 1.0%).
- 1.11 Member Months:** The number of months within a Base Year or a Performance Year that the Participant is eligible and has been Attributed to the VCO.
- 1.12 Performance Year:** The successive twelve-month periods of the contract beginning July 1, 2020, as reflected in Exhibits 1A, 1B and 1C, used as the period for evaluating VCO Quality Performance and calculating the Total Cost of Care.
- 1.13 Risk Score:** Risk Score is a composite score estimating the overall health risk of the VCO's population of Attributed Participants for the Base Year and each Performance Year. The higher the Risk Score the higher the health risk of the population. Risk scores are calculated for each Participant each year using the Milliman MARA CXAdjuster Risk Scoring methodology. Risk Scores will be utilized by the Department to adjust Base Year Actual Cost and the Performance Year Gross Target PMPM to account for changes in the severity of health risk of Attributed Participants between the Base Year and Performance Year. In mathematical form, the calculation of a composite Risk Score is the final risk score for each Participant Attributed to the VCO multiplied by each Participant's Attributed Member Months for the period, all added together and divided by the number of Participant Attributed Member Months with a risk score Attributed to the VCO for the period.
- 1.14 Risk Standardized PMPM:** The calculation of Base Year Actual Cost PMPM divided by Base Year Risk Score as defined in Article 3.3.

- 1.15 Service Area:** The geographic area served by VCO's Healthy Connections Service Locations that has been approved in writing by the Department as defined in Exhibits 1A, 1B and 1C.
- 1.16 Statewide Goal:** The Statewide Goal is set at the higher of the State Average or the National 90th percentile score for Medicaid programs for all quality measures.
- 1.17 Stop Loss:** For purposes of calculating Actual Cost, during the Base Year and each Performance Year, a stop-loss threshold shall apply to any Participant for whom annual aggregate Included Costs exceeds \$100,000. Only twenty percent (20%) of the annual aggregate Included Costs for a Participant in excess of \$100,000 and below \$500,000 will be counted in determining the VCO's Actual Cost. By way of example, if the annual aggregate Included Costs for a Participant is \$200,000 in a Performance Year, only \$120,000 of those Included Costs will be included in the VCO's Actual Cost. No amount of annual aggregate Included Costs for a Participant in excess of \$500,000 shall be included in the VCO's Actual Cost. By way of example, if a Participant's annual aggregate Included Costs is \$600,000, only \$180,000 (20% of \$400,000 = \$80,000 + \$100,000 = \$180,000) shall be included in VCO's Actual Cost.
- 1.18 Total Cost of Care:** The formula, as described in Article III, used to measure and evaluate the VCO's performance in controlling the cost of care provided to Attributed Participants.

Article II

- 2.1 Requirements for AHCO Participation.** This Article II sets forth the requirements for a VCO to participate as an AHCO.
- 2.2 VCO Network.** VCO must maintain a network of providers and facilities per Service Area that includes at a minimum one acute care hospital and a Primary Care Provider (PCP) panel of Healthy Connections Service Locations that have combined a minimum of ten thousand (10,000) Assigned Medicaid Participants.
- 2.3 Satisfactory Assurance of Repayment.** VCO shall demonstrate to the Department's satisfaction that VCO has sufficient financial resources to repay potential shared losses incurred through this Agreement.
- 2.4 VCO Savings Distribution.** VCO shall document the amounts and its methodology for distributing shared savings and/or loss among VCO Network providers and shall make this information available to the Department upon request. The Department shall treat this information as proprietary and confidential as defined in Article 9.14 of the VCO Agreement.
- 2.5 VCO Selection of Level of Risk Sharing.** Prior to the start of each Performance Year, the VCO must select the level of risk sharing it is willing to accept for that Performance Year. The risk sharing level selected by the VCO for the initial Performance Year shall be set forth in Exhibits 1A. Exhibits 1B and 1C shall be amended to specify the selected level of risk for the second and third Performance Years. The level of risk sharing selected must exceed the minimum yearly requirement set forth below and must be equal to or greater than the

level of risk of the previous Performance Year. There are two Risk Sharing options as stated below:

Option 1 – Symmetrical Savings and Loss Risk Sharing

- Share of Savings or Loss must be the same percentage
- Minimum Risk Share Year 1 – 10%
- Minimum Risk Share Year 2 – 25%
- Minimum Risk Share Year 3 – 50%
- Maximum Risk Share each year – 80%

Option 2 – Asymmetrical Savings and Loss Risk Sharing

- Share of Savings or Loss must be as described below
- Year 1 Risk Share 40% of Savings and 20% of Loss
- Year 2 Risk Share 40% Savings and 20% Loss or Option 1 Year 2 terms
- Year 3 Mandatory Option 1 Year 3 terms

Article III

3.1 Total Cost of Care. This Article III sets forth the Total Cost of Care formula for determining the VCO's performance each year in controlling the cost of care provided to Attributed Participants.

3.2 VCO Performance. The VCO's individual performance for each year of the Agreement defined as a Performance Year will be compared to the VCO's previous individual performance during State Fiscal Year 2019 (July 1, 2018 - June 30, 2019) defined as the Base Year.

3.3 Risk Standardized PMPM. A Risk Standardized PMPM will be calculated for each VCO based on the VCO's individual performance during the Base Year as follows:

$$\text{Base Year Actual Cost PMPM} / \text{Base Year Risk Score} = \text{Risk Standardized PMPM}$$

3.4 Gross Target PMPM. Gross Target PMPM shall be calculated for each Performance Year as follows: (1) multiply the Risk Standardized PMPM from the Base Year by the Inflation Trend applicable to that Performance Year; (2) multiply the result by the Performance Year Risk Score. In mathematical form, the calculation is as follows:

$$\text{Risk Standardized PMPM} \times \text{Inflation Trend} \times \text{Performance Year Risk Score} = \text{Gross Target PMPM}$$

3.5 Performance Year Savings or Loss. To determine the VCO's performance in controlling cost each Performance Year the Department will compare the Gross Target PMPM to the Actual Cost PMPM for the Performance Year to determine if the VCO has generated a savings or loss for the period. In mathematical form, the calculation is:

$$\text{Gross Target PMPM} - \text{Actual Cost PMPM} = \text{Performance Year Savings (Loss) PMPM}$$

- 3.6 Gross Performance Year Savings or Loss.** Gross Performance Year Savings or Loss shall be calculated by multiplying the Performance Year Savings or Loss PMPM by total Member Months Attributed to the VCO during the Performance Year. Mathematically, the calculation would be:

$$\text{Performance Year Savings (Loss) PMPM} \times \text{Member Months} = \text{Gross Performance Year Savings (Loss)}$$

Article IV

- 4.1 VCO Distribution of Performance Year Savings.** This Article IV sets forth the methodology for determining the total distribution owed by Department to the VCO in the event of Performance Year Savings.
- 4.2 Minimum Savings Threshold.** Gross Performance Year Savings must exceed **XX** percent (**XX%TBD**) of the Gross Target to trigger Department's liability to VCO for any portion of Gross Performance Year Savings; provided, however, that if Gross Performance Year Savings exceeds the **XX** percent (**XX%TBD**) threshold, all savings will be included in the calculation of Department's liability to VCO for a portion of Gross Performance Year Savings.
- 4.3 Total Funds Eligible for Distribution.** The total funds eligible for distribution to VCO shall be calculated by multiplying the Gross Performance Year Savings by the VCO's selected level of risk sharing as defined in Exhibits 1A, 1B and 1C. Mathematically, the calculation would be:

$$\text{Gross Performance Year Savings} \times \text{VCO Risk Sharing Percentage} = \text{Total Funds Eligible for Distribution}$$

- 4.4 Dividing Total Eligible Funds into Quality and Efficiency Pools.** The Total Funds Eligible for distribution to VCO shall be divided equally into two pools, a Quality Pool and an Efficiency Pool.
- 4.5 Qualifying for Distribution of Efficiency Pool to VCO.** VCO shall be eligible to receive all of the funds in the Efficiency Pool provided it maintains or exceeds the Quality Measures Baseline Score for at least 70% of the VCO's Quality Measures that are measurable, excluding the Quality Measures that are report only. The Quality Measures Baseline Score is determined for each Performance Year as defined in Exhibit 1E. If the VCO does not maintain or exceed the Baseline Score for at least 70% of the Quality Measures, there will be no distribution of funds from the Efficiency Pool.
- 4.6 Calculating Distributable Share of Quality Pool.** VCO shall be eligible to receive the percentage of funds available in the Quality Pool based on its quality outcomes for the Performance Year as calculated in Exhibit 1E.

- 4.7 Final Distribution to VCO.** The Department shall owe in the form of performance incentives the lesser of: (1) the sum of the Efficiency Pool funds for which VCO qualifies and the

share of the Quality Pool earned by VCO; and (2) an amount equal to fifteen percent (15%) of the applicable Gross Target for the Performance Year.

Article V

- 5.1 Payment by VCO in the Event of Performance Year Loss.** This Article V sets forth the methodology for determining the amount owed by VCO to Department in the event of a Performance Year Loss.
- 5.2 Minimum Loss Threshold.** Gross Performance Year Loss must exceed **XX** percent (**XX%**) of the Gross Target to trigger VCO's liability to Department for any portion of Gross Performance Year Losses; provided, however, that if Gross Performance Year Loss exceeds the **XX** percent (**XX%**) threshold, all losses will be included in the calculation of VCO's liability to Department for a portion of Gross Performance Year Loss.
- 5.3 VCO Obligation for Performance Year Loss.** The amount the VCO is required to pay the Department in the event of a Performance Year Loss shall be calculated by multiplying the Gross Performance Year Loss by the VCO's selected level of risk sharing as defined in Exhibits 1A, 1B and 1C. Mathematically, the calculation would be:
- $$\text{Gross Performance Year loss} \times \text{VCO Risk Sharing Percentage} = \text{Total Funds Owed to the Department}$$
- 5.4 Final Payment Obligation.** The VCO shall pay to the Department for its shared risk of Performance Year losses the lesser of: (1) the Total Funds Owed to the Department; and (2) an amount equal to fifteen percent (15%) of the applicable Gross Target for the Performance Year.
- 5.5 Timely Reporting and Data Condition.** In addition to any other remedies available to VCO, in the event that Department does not timely fulfill its obligations under this Agreement to provide data and reports as set forth herein and in the separate Data Use Agreement and that the failed obligation had a material impact on performance, VCO shall submit written notice to the Department of such failed obligation and impact. If the Department does not resolve the issue and come into compliance with this Agreement or Data Use Agreement within 30 days of the written notice the VCO shall have no obligation to pay any part of a Performance Year Loss.

ARTICLE VI

- 6.1 Settlement Process.** This Article VI sets forth the methodology for annual settlement for each Performance Year.
- 6.2 Performance Year Attribution Report.** No later than forty-five (45) days following the end of each Performance Year, the Department shall provide to VCO a report showing the

Participants Attributed to the VCO for the applicable Performance Year. The report shall reflect the total number of months each Participant was Attributed to the VCO, the total number of months the Participant was enrolled in the Healthy Connections Program during the Performance Year, and the number of months during which the Participant was Assigned to a Healthy Connections Service Location participating in the VCO.

6.3 Performance Year Settlement Reports. No later than one hundred fifty (150) days following the end of the Performance Year, the Department shall provide to VCO reports including each of the following elements:

6.3.1 Draft Settlement. A draft settlement for the Performance Year, including the Department's calculation of amounts owed by Department to the VCO or owed by the VCO to the Department, if any.

6.3.2 Participant Report. A report reflecting the final list of Participants Attributed to the VCO and the risk score for each Participant.

6.3.3 Quality Performance Report. A detailed report showing the results of the Quality Performance Program, including detail of which Participants are included in the calculation and whether the performance measure was met for each included Participant.

6.3.4 Financial Performance Report. A detailed report sufficient to show the Department's calculations, and for VCO to validate the calculations, set forth in Articles III, IV and V of this Exhibit 1.

6.4 VCO Response to Draft Settlement Report. By a date no later than forty-five (45) days from the date when VCO receives the last of the Performance Year Settlement Reports, as defined in Article 6.3, VCO shall accept or object to the Draft Settlement in writing delivered according to the notice provisions of the VCO Agreement.

6.5 Dispute Resolution in the Event of Objection. If VCO objects to the Draft Settlement, such objection shall be resolved by following the dispute resolution provisions of the VCO Agreement.

6.6 Settlement Finalization. The Draft Settlement shall become final (the "Final Settlement") upon the later of the date upon which: (1) the Department receives VCO's written acceptance of the Draft Settlement; and (2) any objection raised by the VCO is finally resolved. Additionally, the Draft Settlement shall become final if the VCO fails to respond to the Department in writing regarding the Draft Settlement Report as described in Article 6.3 and Article 6.4.

6.7 Timing of Payment. In the event the Final Settlement reflects a Distribution owed by Department to the VCO, the Department shall make such payment within sixty (60) days of

the date upon which the Draft Settlement becomes final. In the event the Final Settlement reflects a Payment Obligation owed by VCO to the Department, the VCO shall make such payment within sixty (60) days of the date upon which the Draft Settlement becomes final. As used in this section, “days” shall be counted as calendar days.

Notice requirements - Any report or communication called for pursuant to this Article VI shall be delivered pursuant to the notice provision of the agreement; provided, however, that if the Department makes the report or data available through a portal or other on-line repository, the Department shall separately provide notice of the availability of the reports or data pursuant to the notice provisions.

Article VII

- 7.1 Fee For Service Reimbursement.** This Article VII sets forth the rates and methodology of fee for service reimbursement to VCO Network Providers for covered services provided to Participants. VCO Network Provider fee for service reimbursement for covered services provided to Participants may or may not be affected by participation in the Healthy Connections Value Care Program as described in this Article VII.
- 7.2 Acute Care Hospital Reimbursement.** Effective July 1, 2020 any VCO participating Acute Care Hospitals currently reimbursed on a cost basis and participating in subsequent period cost settlements, will be paid for hospital services provided to all Medicaid Participants, including those assigned to the VCO, those assigned to other VCOs and those not assigned to a VCO but are still eligible for services under other Department programs, at the interim rates in effect as of July 1, 2020 and such rates will remain in effect for the duration of this VCO Agreement with the exception of charge master changes and inflation adjustments, as applicable, as noted below.

In the event there is an overall charge master increase implemented after July 1, 2020, a new interim rate will be established for all covered services paid on a discount from charges methodology. The new interim rate will be in effect for covered services provided after the effective date of the charge master increase and will be determined according to the formula below, rounded to the nearest tenth of a percent.

New Discount = $1 - (1 - \text{current discount}) / (1 + \text{charge master increase in excess of the Inflation Trend})$

New Interim Rate = $100\% - \text{New Discount}$

For example, assuming a current discount of 60%, an Inflation Trend as established under the terms of this Exhibit of 4.0% and a charge master increase of 5.0% the new discount would be calculated as follows:

New Discount= $1 - (1-.6)/(1+ (.05-.04)) = 60.40\%$

New Interim Rate: $100\% - 60.40\% = 39.60\%$

The intent of this section is to allow Hospitals to modify its customary charge masters while assuring that the annual increases in the charge master does not have the impact of increasing fee for service reimbursement to Hospitals under this Agreement by more than the Inflation Trend agreed to by the Parties and established in this Exhibit.

There will be no other interim rate changes during the term of this VCO Agreement except for the change stated above with regard to charge master increases.

The cost settlement process for VCO participating Acute Care Hospitals will also be modified. There will be no Cost Settlement for hospital services provided to Participants during those time periods when the Participant was Attributed to the VCO. The Cost Settlement process will still be in effect for all other hospital services provided to Medicaid Participants including services provided to Participants not Attributed to the VCO.

The Upper Payment Limit (UPL) and Disproportionate Share Hospital (DSH) adjustments will stay in effect for services provided to all Medicaid Participants both VCO Attributed and not Attributed to the VCO.

- 7.3 All Other Facilities Reimbursement.** These facilities will be reimbursed for services provided to all Medicaid Participants at the rates defined in their Medicaid contract.
- 7.4 Physicians and Other Professional Providers Reimbursement.** All other participating VCO providers will be reimbursed for services provided to all Medicaid Participants at the rates defined in their Medicaid contract. HCVC Primary Care Providers will also still receive the PMPM Case Management fee as listed in their Medicaid contracts.
- 7.5 Adjustment to Account for Changes in Reimbursement.** If the Department changes its provider reimbursement methodology or rates during the Performance Year, those changes shall be accounted for by increasing or reducing the Performance Year Gross Target PMPM for the Performance Year following the change in the methodology to the degree that it was impacted by those rates or methodology changes.

Exhibit 1A

Financial Terms -Year 1

Performance Year 1	July 1, 2020 – June 30,2021
Base Year	July 1, 2018 – June 30, 2019
Base Year Actual Cost	
Base Year Member Months	
Base Year Actual Cost PMPM	
Base Year Risk Score	
Risk Standardized PMPM	
Performance Year Risk Score Performance Year Risk Score is estimated during the Performance Year based on Assigned Participants and finalized during the year end settlement process based on VCO's Attributed Participants	
Inflation Trend	$[1 + \text{Index \#1}(2019\text{MMI}\%)] \times$ $[1 + \text{Index \#2}(2020\text{MMI}\% \text{ or } \text{Index \#1 } +/-1\%)]$
Gross Target PMPM Gross Target PMPM is estimated during the Performance Year Based of Assigned Participants and finalized during the year end settlement process based on Attributed Participants	
Level of Risk Sharing	
Service Area	

Exhibit 1B

Financial Terms - Year 2

Performance Year 2	July 1, 2021 – June 30, 2022
Base Year	July 1, 2018 – June 30, 2019
Base Year Actual Cost	
Base Year Member Months	
Base Year Actual Cost PMPM	
Base Year Risk Score	
Risk Standardized PMPM	
Performance Year Risk Score Performance Year Risk Score is estimated during the Performance Year Based on Assigned Participants and finalized during the year end settlement process based on VCO's Attributed Participants	
Inflation Trend	$[1 + \text{Index \#1}] \times$ $[1 + \text{Index \#2}] \times$ $[1 + \text{Index \#3}(2021\text{MMI}\% \text{ or Index \#2 } \pm 1\%)]$
Gross Target PMPM Gross Target PMPM is estimated during the Performance Year Based of Assigned Participants and finalized during the year end settlement process based on Attributed Participants	
Level of Risk Sharing	
Service Area	

Exhibit 1C

Financial Terms - Year 3

Performance Year 3	July 1, 2022 – June 30, 2023
Base Year	July 1, 2018 – June 30, 2019
Base Year Actual Cost	
Base Year Member Months	
Base Year Actual Cost PMPM	
Base Year Risk Score	
Risk Standardized PMPM	
Performance Year Risk Score Performance Year Risk Score is estimated during the Performance Year based on Assigned Participants and finalized during the year end settlement process based on VCO's Attributed Participants	
Inflation Trend	$[1 + \text{Index \#1}] \times$ $[1 + \text{Index \#2}] \times$ $[1 + \text{Index \#3}] \times$ $[1 + (2022\text{MMI}\% \text{ or Index \#3 } \pm 1\%)]$
Gross Target PMPM Gross Target PMPM is estimated during the Performance Year Based of Assigned Participants and finalized during the year end settlement process based on Attributed Participants	
Level of Risk Sharing	
Service Area	

Exhibit 1D

Included & Excluded

Included Costs. The following costs shall be included when calculating Actual Cost:

- Diagnostic services (lab tests, imaging, etc.)
- Durable medical equipment
- Emergency medical transport
- Hospice Care
- Home Health services
- Inpatient Hospital services
- Outpatient Hospital services
- Inpatient behavioral health
- Outpatient facilities including ambulatory surgery
- Professional services (primary care, specialty care, physical therapy, speech therapy, etc.)

Excluded Costs. The following costs shall be excluded when calculating Actual Cost:

- Behavioral health services administered through a managed-care contract
- Dental services administered through a managed-care contract
- Home and Community-Based Waiver Services (e.g. services provided to participants in their home or community rather than institutions, such as personal care services or meals)
- Long-term Supports & Services
- Non-emergent medical transportation services administered through a managed-care contract
- Nursing Home or Intermediate Care Facilities
- Pharmacy
- Skilled Nursing
- Health Connection Case Management Payments

Excluded Participant Categories.

This paragraph identifies the categories of Medicaid Participants who may be Assigned to a Healthy Connections Service Location within the VCO, but who are excluded from the Total Cost of Care calculation and the Quality Performance Program. Medicaid Participants not Assigned to a Healthy Connections Service Location are excluded from this Agreement.

- Dual-eligible Participants (eligible for both Medicaid and Medicare)
- Participants made eligible through the Medicaid Expansion Initiative

Exhibit 1E

Quality Performance Program

The goal of the Quality Performance Program is to incentivize continuous improvement in measured performance areas. The Healthy Connections Value Care Program is using quality measures to show how well the VCO is improving care and making quality care accessible while appropriately reducing the Actual Cost.

Common Set of Quality Measures

The Performance Year 1 Quality Measures were selected with input received from multiple stakeholders. The ten (10) quality measures that were selected for Performance Year 1 are outlined in Table 1 that follows:

Table 1: Quality Measures

	Healthy Connections Quality Measures*	Source	Endorsed By	State Average	90% of National
1	(Adult) DIABETES HBA1C TEST indicates whether a Participant with type 1 or type 2 diabetes, aged 18 to 75 years, had a hemoglobin A1c test performed.	Claims	NQF 57; Owned by NCQA	XX	XX
2	WELL CHILD VISITS (>5) IN FIRST 15 MOS MCD CHILD indicates the percentage of Participants, who turned 15 months old, and had more than five well-child visits with a Primary Care Provider (PCP) during their first 15 months of life.	Claims	NQF 1392; Owned by NCQA	XX	XX
3	WELL CHILD VISITS AGE 3 TO 6 YEARS MEDICAID CHILD indicates the percentage of Participants, aged 3 to 6 years, who received one or more well-child visits with a Primary Care Provider (PCP) during the measurement year.	Claims	NQF 1516; Owned by NCQA	XX	XX
4	WELL CARE VISITS ADOLESCENTS MEDICAID CHILD indicates the percentage of Participants, aged 12 to 21 years, who had at least one comprehensive well-care visit with a Primary Care Provider (PCP) or a gynecologist during the measurement year.	Claims	HEDIS; Owned by NCQA	XX	XX
5	BREAST CANCER SCREENING indicates whether a female Participants, aged 52 to 74 years, had a mammogram done from 27 months prior to the measurement period to the end of the measurement period.	Claims	NQF 2372	XX	XX

6	AMBULATORY CARE EMERGENCY DEPT VISITS Calculates the number of emergency department (ED) visits per 1,000 enrolled months.	Claims	HEDIS	XX	XX
7	READMISSIONS WITHIN 30 DAYS AGE 18 TO 64 and READMISSIONS WITHIN 30 DAYS AGE > 64 calculates the percentage of acute inpatient stays during the reporting time period, for Participants aged 18 years and older, that were followed by an acute readmission for any diagnosis within 30 days of discharge.	Claims	NCQA	XX	XX
8	*Elective Delivery - assesses patients with elective vaginal deliveries or elective cesarean births at ≥ 37 and < 39 weeks of gestation completed.	VCO Report on all Medicaid patients	NQF 469; CDC; Owned by the Joint Commission		
	*Catheter-associated urinary tract infections (CAUTI) Standardized Infection Ratio (SIR) of healthcare-associated, catheter-associated urinary tract infections (UTI) will be calculated among patients in bedded inpatient care locations, except level II or level III neonatal intensive care units (NICU).	VCO Report on all Medicaid patients	NQF 138; NHSN/CDC Steward; Hospital Compare		
	*Clostridium difficile (C-diff) Standardized Infection Ratio (SIR) of hospital onset of clostridium difficile bacterial infection hospital onset among all inpatients in the facility.	VCO report on all Medicaid patients	NQF 1717; NHSN/CDC Steward		
9	H CAHPS (Communication about medication) Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?	VCO Report on all Patients	CMS HCAPS Hospital Survey		
10	H CAHPS (Discharge Information) During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?	VCO Report on all Patients	CMS HCAPS Hospital Survey		

- All qualifying Quality Measures are included in the VCO's Quality Pool Funds payment calculation. To be considered a "qualifying" Quality Measure, the VCO shall have a minimum of 30 Participants included in the measure's denominator.
- The Quality Measure's Baseline Score will be determined as follows:
 - Performance Year 1 - is based on Participants attributed to the VCO for SFY 2019. Baseline calculation to occur upon receipt of contract identifying participating Healthy Connections Service Locations.
 - Performance Year 2 and Year 3 - are based on Participants attributed to the VCO for the year prior to the Performance Year.
- The Quality Measure performance outcome will be calculated annually based on the Participants Attributed to the VCO as of the last day of the performance period.
- VCO Participating acute care hospitals shall be responsible for reporting the three (3) hospital clinical measures and two (2) HCAHP survey data to the Department by the end of the first quarter, following the Performance Year end.

Quality Pool Performance Payment Targets

Payments to the VCO from the Quality Pool will be established based on its performance in meeting Quality Measure improvement targets or Statewide Goal, as outlined below. Targets will be re-evaluated based on the prior year performance (baseline).

Statewide Goal

The statewide goal is set at the higher of the Statewide average or the National 90th percentile score for Medicaid programs.

Incremental Annual Improvement Targets

VCO shall demonstrate at least a 3% minimum improvement from their individual baseline. Improvement targets encourage continued, incremental year-over-year improvement toward the statewide benchmark over time. Each VCO's Quality Measure Performance Target will be published by the Healthy Connections Value Care Program prior to the Performance Year.

This method requires at least a 10 percent reduction in the gap between baseline and the statewide goal to qualify for incentive payments. Or, stated as a formula:

$$\frac{[\text{State Goal}] - [\text{VCO Baseline}]}{10} = X \qquad [\text{VCO Baseline}] + [x] = \text{Improvement Target}$$

For example: a VCO's baseline for the timeliness of well-child visits in first 15 months measure may be 30 percent. Idaho has set the goal at 70% percent.

$$\frac{[70] - [30]}{10} = 40$$

$$[30] + [4] = 34 = \text{Improvement Target}$$

The VCO must reduce the gap between its baseline and the goal by 10 percent; therefore, the VCO must improve its rate on the timeliness of well-child visits in first 15 months measure by 4 percentage points, resulting in an improvement target of 34 percent.

The VCO must meet either the statewide goal of 70% percent or the improvement target of 34% percent to be awarded quality performance payment funds for this measure.

Improvement Target with Floor Calculations

In some cases, depending on the difference between the statewide goal and the VCO baseline, this method may result in very small improvements that may not represent statistically significant change.

For example: A VCO's baseline for the breast cancer screening may be 49.8 percent. The state benchmark could be set at 51.0 percent.

Initial calculation

$$\frac{[51.0] - [49.8]}{10} = 0.12$$

Improvement target

$$49.8 + 0.12 = 49.92$$

If the improvement target calculation for a VCO results in a percent improvement that is less than the minimum, the minimum takes precedence and is applied instead of the improvement target calculation. For example, if the a VCO's baseline was 50.6 with the statewide goal set at 70.0 for the well child measure, the improvement target calculation results in only a 1.94 percentage point increase in the rate, the 3% point minimum is used instead to determine an improvement target.

Using the formula, based on State's Aspirational goal = 70%; VCO B's baseline = 50.6%)

Initial calculation due to minimum floor

$$\frac{[70.0] - [50.6]}{10} = 1.94$$

Improvement target

$$50.6 + 1.94 = 52.94$$

New Improvement target

$$50.6 + 3.0 = 53.6$$

However, if a second VCO's baseline was only 35% on this measure, its improvement target would be greater than the 3-percentage point floor, and the floor would not be applied. Its improvement target would remain the initial calculation.

***Initial calculation
applied.***

Improvement target

New improvement target with floor

$$\frac{[70.0] - [35.0]}{10} = 3.5$$

$$35.0 + 3.5 = 38.5$$

Not needed; greater than 3% improvement

In some instances, the improvement target calculation for a measure could exceed the established statewide goals. In this case, the VCO must only meet the statewide goal to be awarded the quality pool funds for that measure. For example, with the breast cancer measure, the state benchmark is set at 68.0 percent. A VCO have a baseline of 66.7. Using the formula:

Initial calculation

Improvement target

New improvement target with floor applied

$$\frac{[68.0] - [66.7]}{10} = 0.13$$

$$66.7 + 0.13 = 66.8$$

$$66.7 + 3 = 69.7$$

But: the individual improvement target in this case is the state benchmark = 68.0

The calculated improvement target (69.7 percent) is higher than the established goal (68.0 percent). The VCO must only meet the goal of 68.0 percent to be awarded the quality pool funds for this measure. It does not need to meet the calculated improvement target when the improvement target is higher than the goal to qualify.

Quality Pool Performance Payments

If the statewide goal is met or the improvement target reached for a specific measure, the VCO receives credit for that measure, regardless of performance on other measures.

Quality Performance Payment Distribution

As an organization meets more statewide goals or improvement targets, it receives a higher payment (see *Quality Performance Payment Distribution* tables below). If the VCO does not meet the improvement target or statewide goal on any of their designated measures, the VCO would not receive any quality performance payment funds.

AHCOs will have a total of 10 potential Quality Measures the first year. The following tables outline examples of the performance payment percentage by measure for which a VCO would be eligible for, based on the number of applicable measures.

Table 2: Example of Performance Payment if 10 Applicable Quality Measures

VCO with 10 Applicable Measures Example		
Percentage of targets of Applicable Value Care Measures Met (achieving statewide goal or improvement target)	Quality Performance Payment Amount	VCO A: (10 Applicable Measures) Number of Measures to Meet
Met at least 70% of applicable measures	100%	7
Met at least 60%	86%	6
Met at least 50%	71%	5
Met at last 40%	57%	4
Met at least 30%	43%	3
Met at least 20%	29%	2
Met at least 10%	14%	1
Met no targets	0	0

Quality Measures Under Consideration for Future Years

Idaho Medicaid will be collaborating with participating VCOs and a broad group of stakeholders on the development of future year quality measures to make sure the measures are important to both participants and VCOs and will achieve the goal of improving population health outcomes and reducing healthcare costs. Each year Idaho Medicaid will publish, by the end of the third quarter, the set of Quality Measures that will apply to participating VCOs the following year. With a Department focus on Primary and Behavioral Health Care Integration, future Behavioral Health measures may include:

- Developmental Screening
- Depression acute and continuation phase therapy
- ADHD drug initiation and continuation phase visits

Exhibit 1F

Healthy Connections Service and Acute Care Hospital Locations

The following is a list of Healthy Connections Service Locations and Acute Care Hospital Locations that are participating with the VCO under the terms of this Agreement.

Acute Care Hospital Locations				
Organization Name	Service Location Name	Address	Tax ID	

Healthy Connections Service Locations				
Organization Name	Service Location Name as listed on HC network listing	Address	NPI HC PMPM Paid To	Tax ID HC PMPM Paid To

Exhibit 1G

Attribution Methodology

Participants are Attributed to a VCO for purposes of calculating the Total Cost of Care (TCOC) formula and Quality Program as follows.

1. Prior to the beginning of each Performance Year the VCO must identify the Healthy Connections Service Locations (HCSL) participating with the VCO in the Healthy Connections Value Care (HCVC) Program.
2. Participants will be Attributed to a VCO based on the Participant's Assignment to a VCO-participating Healthy Connections Service Location in accordance with the policies and procedures of the Healthy Connections Program.
3. In order for a Participant to be Attributed to a VCO in the Base Year and in a Performance Year, the Participant must be Assigned to the VCO a minimum of seven (7) months. A Participant may be Assigned to multiple different Healthy Connections Service Locations within the same VCO to qualify.
4. Included in the calculation of the VCO's TCOC will be all member months and TCOC claims (Actual Costs) paid during the period of Attributed Participants while the Participant was a Healthy Connections Program Participant. For example, if a Participant was Assigned to a HCSL in VCO 1 for 7 months and another HCSL in VCO 2 for 5 months, all 12 member months and all claims paid for the year would be Attributed to VCO 1.
5. Examples of Attribution process.

Ex 1: 12 months of Healthy Connections Program eligibility

- 7 months Assigned to VCO 1
- 5 months Assigned to VCO 2

Participant would be Attributed to VCO 1 for the entire 12-month period and all claims incurred during the period would be Attributed to VCO 1 and included in the TCOC calculation.

Ex. 2: 7 months of Healthy Connections Program eligibility

- 7 months Assigned to VCO 1
- 5 months eligible for Medicaid but not enrolled in the Healthy Connections Program

Participant would be Attributed to VCO 1 for the 7 months they were assigned to VCO 1 and all claims incurred during the period would be Attributed to VCO 1 and included in the TCOC calculation.

Ex. 3: 10 months of Healthy Connections Program eligibility

- 7 months Assigned to VCO 1
- 3 months Assigned to VCO 2
- 2 months eligible for Medicaid but not enrolled in the Healthy Connections Program

Participant would be Attributed to VCO 1 for the 10-month period that the participant was enrolled in the HCVC Program and all claims incurred during the period would be Attributed to VCO 1 and included in the TCOC calculation.

Ex. 4: 12 months of Healthy Connections Program eligibility

- 6 months Assigned to VCO 1
- 6 months Assigned to VCO 2

Participant would not be Attributed to either VCO due to the Participant not meeting the 7-month minimum Assignment requirement to qualify for Attribution.

Ex 5: 9 months of Healthy Connections Program eligibility

- 7 months Assigned to VCO 1
- 2 months Assigned to VCO 2
- 3 months eligible for Medicaid but not enrolled in the Healthy Connections Program

Participant would be Attributed to VCO 1 for the 9-month period that the Participant was enrolled in the HCVC Program and all claims incurred during the 9-month period would be Attributed to VCO 1 and included in the TCOC calculation.

Ex. 6: 6 months of Healthy Connections Program eligibility

- 6 months Assigned to VCO 1

Participant would not be Attributed to VCO 1 due to the Participant not meeting the 7-month minimum Assignment requirement to qualify for Attribution.

Exhibit 1H
Data Use Agreement